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S 000	Initial Comments Complaint# 1642969/IL85889 Statement of Licensure Violations	S 000		
S9999	Final Observations 1 of 2 licensure violations 300.610a) 300.670a) 300.670c)1)2)3) 300.670d) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.670 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for	S9999	**Attachment A** **Statement of Licensure Violations**	

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each shift of facility personnel. Drills shall be held under varied conditions to:
1) Ensure that all personnel on all shifts are trained to perform assigned tasks;
2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and
3) Evaluate the effectiveness of disaster plans and procedures.
d) Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

1 of 2)Based on record review and interview the facility knowingly failed to follow their fire evacuation policy during an actual fire. Facility staff did not notify fire personnel of residents left in the burning building. Facility staff failed to follow policy/procedures for leaving smoke barrier doors closed to contain the fire and smoke. Facility staff neglected to evacuate the residents closest to the fire first and those away from the

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fire origin later. Facility staff evacuated the entire facility without clear instructions from any person in charge. Facility management staff neglected to ensure that all staff was adequately trained to respond to an actual fire, resulting in poor communication and a prolonged relocation of all 106 residents. These failures resulted in fire department personnel using search and rescue operations to recover four residents. These failures resulted in fourteen residents (R1-R6, R11-R15, R19, R23, R24) requiring hospital visits for smoke inhalation and other fire related conditions including anxiety/panic attacks.
2 of 2)Based on interview and record review, the facility failed to maintain a functioning Quality Assurance Committee which develops and implements appropriate plans of action to correct identified quality deficiencies and to monitor the effects of these corrective actions. This has the potential to affect all 106 residents living at the facility.

Findings include:
Facility "Fire Safety and Disaster Preparedness Manual" (revised 03/31/13) documents the following: "the main objective and first consideration during any disaster or emergency is the safety and well-being of the residents. Employees should always remain calm and reassure the residents so that transfer or evacuation procedures can be carried out effectively and with the least amount of problems or accidental injury." This same manual also documents the following: "In case of any emergency, evacuation of residents, staff, and visitors should first be from the area of immediate danger. If a complete evacuation from the facility becomes necessary, residents are to be removed from the facility utilizing the nearest and safest exits and taken outside to the front parking lot

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where a head count will be taken."
On 05/31/2016 at 5:10PM Z13 (Illinois Department of Health Emergency Services Coordinator) states he notified Z14 (Illinois Department of Public Health Field Supervisor) that there was a fire with total resident evacuation at facility.
Fire Department form NFIRS-1 dated 05/31/2016 documents that the local fire department " responded for a reported fire in a room on the 500 hall (E) at the facility. This same report documents that upon arrival of fire units and personnel they found heavy smoke coming from the right rear of the building located near (F) and (E) hallways with police officers and employees from the business breaking windows to remove residents from the 500 hall.
This same document reports that "fire personnel ...found the fire quickly and contained to room 509 while other fire personnel were in rescue operations. It was at this time that several residents were still inside (500 Hall) where a female victim (resident) was found in the hallway. Primary searches were performed (by fire personnel) from room 501 to 516 where several victims were found. One male (resident) was removed from room 503 through the window. In room 505 a male resident was removed through a window. A male resident from room 506 was removed out of the room and down the hallway in a wheelchair."
On 06/15/2016 at 1:30PM Z10 (Emergency Management Services/EMS Operations Manager) stated that when he arrived on the scene no facility staff were in charge for the first 15 minutes. Z10 stated that after that, E2 (Facility Regional Operations Manager) assumed control. Z10 stated that when they arrived, facility staff could not tell them how many residents were still in the building. Z10 stated, "There was no

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coordination whatsoever." Z10 stated it took 45 minutes to one hour after their arrival for EMS to be given any kind of information about resident's medical needs only to be asked by E2 (Facility Regional Operations Manager) for their (EMS) plan to find placement for residents.
E2 provided a 54 page document titled Fire Safety and Disaster Preparedness Manual (Revised 3/31/2013) on 6/1/2016. Pages 19-25 include names, addresses, and contact information as well as skill level for area nursing home facilities. However, during the fire response, Z13's (Emergency Services Coordinator) written account indicates that "there was quite a bit of confusion regarding the actual number of nursing home residents present, how many still required transport and the destination of those waiting. I heard resident numbers from multiple people that ranged from 103-106 ...Illinois Department of Public Health (IDPH) Long Term Care (Z14, Z15, Z16) along with a Senior Citizen Ombudsman were attempting to lock down Nursing Home bed availability in the region. There was no pre-planned sheltering facility identified by management to get these residents out of the elements which included the threat of rain and at times visible lightening."
On 06/16/2016 at 5:30PM Z1 (local Fire Chief) stated that he and his men rescued a total of four residents from the fire hall, (500 hall) with one resident rescued by accident when Z1 and some of his men were standing at the entrance to room 509 (where fire started). When Z12 (Fire Department Captain) stepped back and bumped into a person on the hall corridor floor. Fire personnel checked to see if the person was alive. The person (resident) moaned and then Z12 helped to evacuate her. Z1 also stated that no nursing personnel of the facility informed him of any potential residents left in the building.

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On 06/16/2016 at 5:40PM Z12 stated that no facility staff informed him of anyone in the building. When Z12 entered the 500 hall and got to room 509 he heard a moan coming from the corridor floor just outside room 509. He then helped to evacuate R1, who resided in room 509.
On 06/16/2016 at 5:30 pm Z1 stated that when he arrived on the scene and was about to enter the facility, Z1 was met by two nursing staff with masks on. Z1 asked the two nursing staff if there were any residents in the building. The two staff members did not provide any answers and instead ran back into the building and Z1 lost them in the smoke. Z1 stated when he entered the 500 hall from the core area (nursing station) he noticed the entrance to 500 hall was standing open which allowed the smoke to get into the core area. Z1 stated that he would have expected the door to have been closed. Z1 stated that nursing staff was "out of control. Staff was all over the scene. They did not follow directions and kept moving (residents) without permission causing problems for resident movements."

Page 8 of the Fire Safety and Disaster Preparedness Manual (Revised 3/31/2013) documents that staff is to "once outside the facility, account for all residents, visitors and staff and report any missing persons to the fire department or other local law agency personnel at once."
Page 9 of this manual instructs staff to "remain calm. If the fire is minor enough to be fought safely, do so. Movement in an evacuation due to fire should always be away from the travel of the heat and smoke. Residents should always be moved to an area that places a fire barrier door between them and the fire, removing those closest to the danger first. Fire and smoke

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barrier doors provide temporary (1-2 hour) protection from the spread of fire and smoke. Fire and smoke barrier doors separate all the halls from the facility core and will automatically close when the fire alarm is activated. At no time should barrier doors be propped open."
On 06/16/2016 at 11:00 AM E1 (Maintenance Supervisor) stated that he was working inside the ceiling when he heard someone say there was a fire. E1 stated he got off the ladder and saw smoke down the 500 hall. E1 stated there was a resident lying in the 500 hall, he got a wheelchair and put the resident in it and pushed the resident out through the 500 hall fire door. E1 stated he was unsure who the resident was. E1 also stated that the acting Director of Nursing was present, but he was not sure what she was doing. E1 stated that in the event of a fire, the Administrator runs everything. If the Administrator isn't present, the Director of Nurses is in charge, then the Assistant Director of Nurses, then the Charge Nurse, then Maintenance. E1 stated that the Administrator was not on site and had to be notified by phone. E1 verified that before the fire department arrived, residents were still in the building on the 500 wing. E1 stated that he has never received training about how to train other staff for fire safety; and was given a training manual to use. E1 stated what he teaches in fire safety is how to use the fire extinguisher, what all staff members responsibilities are in case of fire, and evacuation procedures.
On 06/14/2016 at 12:05 pm E10 (Maintenance Assistant) stated that on 05/31/2016 E10 heard a staff person say there was a fire. E10 stated he could see smoke coming from behind the fire door on the 500 hall. E10 entered the 500 hall, saw fire extinguisher lying on the floor, picked it up and started spraying it at the fire. E10 stated he used up two or three extinguishers. E10 then

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noticed (R1) lying in her bed. E10 picked her up, laid her on the floor in the hallway and called for help. E10 saw another resident who he believes is R9 laying on her bed. E10 took her tube feeding machine off the pole, picked her up and laid her on the floor in the hallway and yelled for help. E10 stated at that point somebody yelled "get out of the building," so he exited the building from the fire exit on the 500 hall.
On 06/14/2016 at 12:30PM E11(Licensed Practical Nurse) stated that on 05/31/2016 at 4:15PM an unidentified C.N.A. (Certified Nursing Assistant) came running up the hall saying "there's a real fire." E11 had been instructed by E1 (Maintenance Supervisor) to hold down the fire alarm on the fire panel due to a false alarm earlier. Upon hearing that there was an actual fire, E11 stated she let go of the fire alarm switch and ran down the 500 hall where E11 saw smoke. E11 stated that she observed E5 C.N.A. standing by room 509 holding a fire extinguisher. E5 opened the door to room 509 and sprayed the fire with the extinguisher. E11 stated someone came by with a fire extinguisher. E11 grabbed the extinguisher from them and sprayed the fire. E11 then states she went in to room 511 to check it. E11 made no comment as to whether room 509 was occupied by residents. E11 stated that on 05/31/2016 she was the Charge Nurse (for 500 hall), but she is not sure what the Charge Nurses' duties are in a fire. E11 stated that the nurse assigned to the hall is charge nurse for that hall. As to who is in charge during the fire, E11 stated, "I guess it would be my job to give directions as charge nurse, but I've never been given a job description of exactly what being charge nurse entails, especially with what a fire entails." E11 verified that she is not aware of anyone calling for an evacuation.
Fire Safety and Disaster Preparedness Manual

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(Revised 3/31/2013) documents, "The chain of command at Cahokia Nursing and Rehabilitation is:
1. Administrator
2. Director of Nursing
3. Assistant Director of Nursing
4. Designated Charge Nurse in the facility."
On 06/21/2016 at 2:10pm, E7 (Certified Nursing Assistant) stated that on 05/31/2016 she was on the 500 hall at the time she became aware of the fire. E7 stated that she, E5 (Certified Nursing Assistant), E10 (Maintenance) and E8 (Licensed Practical Nurse) were "working together during the fire but nobody was clearly in charge." E7 stated, "It was overwhelming and everybody was running."
On 06/21/2016 at 10:10 am E26 (Social Services Assistant) stated that to her knowledge, no one placed identification bands on residents at the time they were evacuated. E26 stated the identification bands were located in the Social Services Office at the time of the fire.
E30 (Licensed Practical Nurse) stated on 6/9/2016 at 3:08 pm that she does not know who was in charge on May 31, 2016 at time of the fire. E30 first stated it was the charge nurse, E11 (Licensed Practical Nurse), but then stated that E1, Maintenance Supervisor, was making the decisions and directing E11. E30 evacuated residents on hall 100 without anyone directing her. E30 stated that she saw E13, Quality Assurance/Education/Licensed Practical Nurse, come through the door of 100 hall, saw smoke follow her in and, "just made the decision to evacuate the residents."
Patient List Cahokia Nursing and Rehab with Destination and Hospital records dated 5/31/2016 provided by Z11 (Emergency System Services System Coordinator) document that fourteen residents (R1-R6, R11-R15, R19, R23, R24) from

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four wings were ultimately transferred to four area hospitals due to fire related conditions.
Face sheet dated 9/01/2015 documents that R2's (500 Hall) date of birth is 05/27/27 with diagnoses of Exacerbation of Chronic Obstructive Pulmonary Disease, Dementia, Degenerative Arthritis, Arteriosclerotic Heart Disease, Congestive heart Failure, and Shortness of Breath. The Hospital Physician's Order Sheet dated 5/31/2016 lists an admitting diagnosis of Smoke Inhalation. Hospital Interventions and Assessment dated 5/31/2016 documents that R1 had, "breath sounds course (sic) expiratory wheezes." Hospital Physical Exam dated 5/31/2016 noted that R2 was "coughing up thick black phlegm and subsequently had some emesis in the Emergency Room" as well as "decreased breath sounds." The Hospital Assessment Plan Sheet dated 5/31/2016 indicates that R2 had "fever, maybe due to exposure to heat exposure and possible bronchitis, will treat ...and monitor closely." The Hospital Transfer Summary noted dated 6/01/2016 states R2 "is an 89 year old woman admitted to the hospital on 5/31/2016 with a diagnosis of Smoke Inhalation. There is little information accompanying this patient. There is notation she is a hospice patient, but we do not have confirmation of which agency is involved." R1's (500 Hall) Hospital Inpatient Record face Sheet dated 5/31/2016 lists R1's birthdate as 2/02/1929. Prehospital Care Report Summary for R1 notes "Due to patient upper extremities being contracted ambulance crew was unable to obtain a blood pressure at this time. Blood glucose analysis assessed at this time with a result of 59. Patient administered oral glucose at this time. Patient unable to answer any EMS (Emergency Management Services) questions at this time." Hospital History and Physical Note dated

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5/31/2016 documents " This is an 87 year old ...admitted from the Emergency Room with smoke inhalation. She is a resident of Cahokia Nursing and rehabilitation Center. There was a fire at the facility last evening and she was exposed to smoke. She was experiencing a cough which prompted her visit to the Emergency Room. Problems: Smoke inhalation injury." The Hospital Patient Discharge Instruction sheet dated 6/01/2016 states, "Discharge diagnosis: Smoke Inhalation/Anemia Exacerbation." R 12's (100 Hall) Hospital Face Sheet dated 5/31/2016 notes date of birth as 10/21/1933. Hospital Emergency room Visit report dated 5/31/2016 indicates that R12 "presents via EMS (Emergency Management Service) from nursing home. Patient's nursing home had a fire this evening and when patient was in a bus for transport, he reportedly had a syncopal episode while sitting in his seat ...Patient with history of Cerebral Vascular Accident with right sided weakness and aphasia ... " An Emergency Department Progress Note dated 5/31/2016 at 9:59 pm stated, "It has been reported that the bus was quite warm and nurse noted that a bottle of water the patient had with him was warm when he arrived. Other residents from the same situation have been brought in for similar complaint ...spoke with (Z19) regarding patient and findings and he agreed likely situational syncope due to elevated temperature and hectic environment." Intervention/Assessment Treatment documentation dated 5/31/2016 noted R12's temperature was 99.1 and blood pressure was 199/84. Facility census records for 5/31/2016 indicate R12 resided on 100 hall. Face sheet for R14 (500 Hall) documents that R14's date of birth is 9/19/1950. Emergency Medical Service report for 5/31/2016 notes " female pt (patient) with possible low blood sugar,

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dizziness, and weakness ...patient sitting upright and slumped to the right in her wheelchair. Nursing home staff tells EMS (Emergency Medical Service) that pt has "seemed to be close to passing out, sweating, and is weak. Pt has been outside in triage area for approximately 90 minutes following evacuation from building." The Hospital Emergency room Visit Report dated 5/31/2016 notes "65 year old female presents to Emergency Department ...status post ...fire at Cahokia Nursing and Rehabilitation. Patient was in an unaffected wing. She was evacuated and sat outside for nearly 1.5 hours in the heat when she started feeling dizzy and lightheaded. She feels better now ...has a history of stroke and her right side is affected." The Hospital Emergency Department Progress note dated 5/31/2016 documents that R14 "presents for lightheadedness after being outside ...in mid-80 weather status post fire ...Patient's symptoms are most likely from heat exhaustion."

A Hospital Face Sheet dated 5/31/2016 notes R13 (600 Hall) date of birth as 6/8/1969. Hospital Emergency Room Visit Report dated 5/31/2016 states "46 year old female with history of dementia presents to Emergency Department by EMS (Emergency Medical System) status post fire ...Per EMS, patient was initially short of breath on scene ...shortness of breath resolved once in ambulance. Past medical history-Alzheimer's Disease/Dementia, Cerebral Vascular Accident, Seizures, Bipolar, Depression."

Prehospital Care Report Summary for R6 (300 Hall) documents "Upon arrival pt (patient) was laying on a bed and on non-rebreather at 15 liters, and it was placed over his trach. Pt (patient) was then transferred to the stretcher and was taken to the truck and loaded in the back with other pt. The other pt was a nurse from the facility that knew the pt. Once in the back, vitals

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were taken ...There was no info on the pt except for knowing his name per the other pt." R6's Physician's Certificate of Medical Necessity from a regional hospital dated 5/31/2016 lists diagnosis of Smoke Inhalation. This same document notes,"Reason for transport: oxygen required and unable to self-administer, airway monitoring/suction, contractures upper/lower, incoherent, disoriented level of consciousness." R11's (500 Hall) Prehospital Care Report Summary dated 5/31/2016 notes that R11 is a 37 year old male with history of brain injury due to car accident and is unable to answer any question at this time. Hospital Patient Health Summary dated 5/31/2016 lists "Active Problems: Ileus, Seizure Disorder, Smoke Inhalation ... "

A Hospital Face Sheet dated 5/31/2016 lists R15 (600 Hall) date of birth as 9/08/44. Hospital Emergency Room Visit Report dated 5/31/2016 noted,"Patient presents ...after nursing home where she was a resident had a fire. Patient states she was not in the area of the fire and did not inhale any smoke, but when they were preparing to transport her to another facility, she had increased pulse and shaking as well as feeling anxious. Patient states this has somewhat improved since coming here and son feels it was likely a panic attack."R15 stated on 6/2/2016 when visited in the destination facility that ,"she went to the hospital due to a panic attack."

R15's Prehospital Care Report Summary dated 5/31/2016 notes this Emergency Services transport was "dispatched to an emergency call for Cahokia Nursing and Rehab on fire with multiple pt (patients) outside in parking lot needing transported. This patient is complaining

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of severe anxiety problems at this time ...The patient told EMS (Emergency Management Service) ' I just can't calm down. I was so scared that I wasn't going to make it out of the building in time and I would be burned alive.' The triage team advised EMS that this pt (patient) was not in the area of the fire and was evacuated well before she was in any harm. A staff member of the SNF (Skilled Nursing Facility) advised EMS that this pt (patient) has a severe anxiety problem and is normally very nervous as it is and this situation has made her very nervous. Upon arrival patient found sitting outside in the triage area ...The pt (patient) over all has very high levels of anxiety and is having severe difficulty in calming down and relaxing ... " This same report documents that R15 was transported from the fire scene at 5:47 pm.

Prehospital Care Report Summary for R4 (500 Hall) dated 5/31/2016 documents that R4 was "having chest pain ...Pt (patient) believes that he has swallowed some smoke and that is giving him chest paint. Pt states that the pain is on the right side just below the nipple line and is a constant pain which he rates it at 10/10 pain scale ...pt then stated that he was becoming short of breath so 4L of 02 via a NC was established and pt states that he feels better ... "

R3's (600 Hall) Prehospital Care Report Summary dated 5/31/2016 notes that R3 is 97 years old. Under Comments in this document is listed Dementia with Alzheimer's. The report states that R3 is "conscious, alert, to person only, sitting in a chair and staff states that she isn't acting right. Pt (patient) has a history of dementia and Alzheimer's and is unable to tell us if anything is wrong or if she is in pain. Staff states that before EMS (Emergency Management

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System) arrived she wasn't acting right but now she is in her normal state. Staff states that the pt (patient) is on 4L (liters) of O2 (oxygen) at all times."

Report titled Cahokia Nursing and Rehab Patient List with Destination with date of 5/31/2016 indicates R5, R19, R23, and R24 were also transported to area hospitals on the date of the fire, from the halls of 300, 500, 500, 500, respectively.

On 6/21/2016 at 9:15 AM, Z17, Administrator of Caseyville Nursing and Rehab Center, stated of the 23 residents received from Cahokia Nursing and Rehab on 5/31/2016, only 1 admitted to the Caseyville Nursing and Rehab Center came with a face sheet, with the other face sheets faxed by 11:30 pm. Z17 stated all residents were given supper as they were all hungry. Z18, POC Administrator of Caseyville Nursing and Rehab Center on 6/21/2016 at 11:55 am stated that the residents arrived around 8 pm on 5/31/2016.
The Disaster Preparedness Manual (Revised 3/31/13) on the Introduction page notes "All personnel, on all shifts, will be trained to perform assigned tasks in case of a facility emergency. The training will include:
1. Disaster response procedures
2. Location and proper use of fire extinguishers
3. Established emergency response codes
4. Locale and proper use of manual pull boxes
5. Floor plans and means of egress/exit
6. Assembly areas
7. Location and proper use of fire and smoke barrier doors
8. Evacuation procedures for residents, visitors, and staff
9. Chemical spill procedures
10. Carrying methods for evacuation"

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S9999	Continued From page 15 On 06/14/2016 at 11:12 am, E1 (Maintenance Supervisor) stated that all staff responded to the fire in the manner in which they had been trained. According to E1, he is responsible for training staff on fire safety. E1 stated that he has never received training about how to train other staff for fire safety; E1 said he was given a training manual to use. E1 stated what he teaches in fire safety is how to use the fire extinguisher, what all staff members responsibilities are in case of fire, and evacuation procedures. E1 stated he does fire drills once a month so that every shift gets one at least every 90 days. E1 stated he trains new staff on fire safety during their orientation. E1 stated the facility ' s most recent fire drill was 05/20/2016 on day shift. He stated the purpose of fire drills is so employees know what they have to do and where they're supposed to be. E1 stated residents are not evacuated during drills. E1 stated if fire safety training is done when staff is off, their training is rescheduled. On 6/9/2016 at 3:08 PM, E30 (Licensed Practical Nurse) stated that she is aware that the facility has an emergency plan and that it is kept at the nurses station but has not seen it. She states that she has not been through an actual fire evacuation drill; it was only a verbalized training. E30 stated she evacuated residents on hall 100 without anyone directing her on 5/31/2016. She stated that she saw E13, Quality Assurance/Education/Licensed Practical Nurse, come through the door of 100 hall and saw smoke follow her in and just made the decision to evacuate the residents. E30 was asked how residents were accounted for. She stated that she grabbed the census sheet/room roster for the building and the elopement risk book which is located at the secretary's desk but she did not know who was responsible for that as she stated she was not aware of anyone specific or assigned	S9999		

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to that task.
On 6/9/2016 at 3:45 PM, E24 (Registered Nurse) stated she was not aware of any emergency plan that the facility had regarding this type of event (fire), but she has seen the Cahokia Nursing & Rehabilitation Center Policies, Standards, Protocols, and Procedures Manual dated 01/01/06. E24 stated that she has not had any training where residents are evacuated. When asked who instructed her to evacuate residents on 5/31/2016, E24 stated she saw smoke and started to evacuate residents on 100 hall before moving on to 600 hall. E24 did not know who was in charge or who was to secure the census data sheet in an event of an evacuation. E24 does not know where residents are to be taken when evacuated; she just got them out and away from the building.
All training records related to fire, fire drills, and disaster preparedness were requested from the facility. Based on all available information provided at the time of the survey there is no system in place to effectively track training efforts. Training records are incomplete and in many cases contain illegible signatures making verification of training difficult.
E1 provided documents titled "REPORT OF FIRE DRILL" on 6/14/16, indicating that these were all the documents available.
Monthly Report of Fire Drill documents were provided for June 2015 through November 2015 and January through March 2016. Fire Drill Sign In Sheets were only available for Report of Fire Drill documents dated 6/14/2015 and 7/25/2015. Ten signatures were present on the document dated 6/14/2015 and 17 signatures were present on the document dated 7/25/2015.
The Monthly Report of Fire Drill reports have a series of nine questions with the words YES and NO after them. These questions include:

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1. Was signal received by ADT?
2. What time was signal received?
3. Was all staff aware of their responsibilities?
4. Were any problems noted?
5. Did the fire alarm sound?
6. Were the strobe lights operational?
7. Were the hall fire door closers operational?
9. Were the delayed egress locks released?

At the bottom of this report, it states: "List any problems, corrective actions, and/or teaching required as a result of this drill:
Monthly Report of Fire Drill reports for 8/18/2015, 9/30/2015, 10/13/2015, 11/10/2015, 1/19/2016, 2/21/2016, and 3/18/2016 did not contain specific locations for the "fire"or "fire drill." Reports for September 2015, October 2015, November 2015, January 2016, February 2016, and March 2016 all have YES circled for question 4 " Were any problems noted? " However, the area where facility staff is to identify the problems with corrective action is blank in all cases.
Forms for June and July 2015 are signed and dated. Form for August 2015 is not signed.
Forms dated September through November 2015 and January through March 2016 are signed and dated by E1 (Maintenance Supervisor). There was no document provided for April 2016.
Document provided for May 2016 notes that Monthly Fire Drill was done on first shift 5/20/2016 and contains 26 signatures.
Training record provided for December is dated 12/16/2015 and is titled Disaster Drill Report. This document indicates that the drill was conducted on 7-3 shift. Fourteen signatures are included on this single page document. There is no information on this document to indicate what type of disaster the drill addressed, nor does it give any location. There are also no information/answers given for any of the following questions printed on the Disaster Drill Report.

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"During Drill
1. Did staff use proper judgment?
2. Was announcement made over the intercom?
3. Were residents placed in an area of safety?
4. Were all corridor doors closed?
5. Did staff respond appropriately?
After the Drill
1. Were all staff aware of their responsibilities?
2. Did personnel in different areas of the facility respond promptly?
3. did staff standby until "All Clear" was given?"

B) On 06/14/16 at 11:12am, E1, Maintenance Director, stated he does not participate in the QA(Quality Assurance) Committee. On 07/01/16 at 11am, E36, Laundry/Housekeeping Supervisor, stated she does not participate in QA. On 07/01/16 10:40am, E35, Dietary Manager, stated she does not participate in QA. On 07/01/16 at 12:25, E33, Housekeeper, stated she did not know how to access the QA committee and stated she was unaware the facility had a QA committee. On 07/01/16 at 11:30am, E34, Certified Nursing Assistant, when asked how to access the QA committee, stated she was not sure, " I guess I would ask the Quality Assurance Nurse? " On 07/01/16 at 1:45pm, E13, Quality Assurance Nurse, stated QA has not met since early April 2016 when E41 was Administrator. E13 stated when E41 was Administrator, theQA committee met monthly, but has not met under E3,the current Administrator, and E13 stated there are currently no future meetings scheduled. On 07/01/16 at 12:20pm, E23, Director of Nurses(DON), stated QA has not met since she took the position of DON on 06/02/16 and there are no future meetings scheduled at this time. On 07/01/16, E3, Administrator stated she took the position of Administrator on 04/25/16, and she stated she plans to implement a QA program but

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has not yet done so. E3 stated there has been no QA committee meeting following the 05/31/16 fire at the facility and no future meetings are scheduled at this time.
An undated Quality Assurance Process Improvement and Compliance Policy stated , "This organization will implement and maintain an active quality assurance process and improvement(QA) program ....collect relevant information and data necessary to identify areas of risk, to detect potential opportunities for improvement and to evaluate ongoing systems and processes ....to evaluate and prioritize activities to address areas of risk and opportunities for improvement focusing on areas of high risk, high volume, and problem prone areas." A 672 Census and Condition of Residents dated 06/02/16 showed the facility has a census of 106. The facility could not provide any documentation, such as attendance sign in sheets, that QA meetings had occurred in 2015 or 2016.

(A)

2 of 2 licensure violations
Section 300.625 Identified Offenders
a) The facility shall review the results of the criminal history background checks
b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint -based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending.
c) If the results of a resident' s criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01

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of the Act, the facility shall do the following:
1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender.
2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject ' s name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c) (2), any criminal history record information contained in its files.
d) The facility shall comply with all applicable provisions contained in the Uniform Conviction Information Act.
e) All name-based and fingerprint-based criminal history record inquiries shall be submitted to the Department of State Police electronically in the form and manner prescribed by the Department of State Police. The Department of State Police may charge the facility a fee for processing name-based and fingerprint-based criminal history record inquiries. The fee shall be deposited into the State Police Services Fund. The fee shall not exceed the actual cost of processing the inquiry.(section 2-201.5 (c) of the Act)
f) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements:
1) The facility shall inform the appropriate county and local law enforcement offices of the

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identity of identified offenders who are registered sex offenders or are serving a term of parole, mandatory supervised reelase, or probation for a felony offense who are residents of the facility. If a resident of a licensed facility is an identified offender, any federal, State, or local law enforcement officer or county probation officer shall be permitted reasonable access to the individual resident to verify compliance with the requirement of the Sex Offender Registration Act, to verify compliance with the requirements of Public Act 94-163 and Public Act 94-752, or to verify compliance with applicable terms of probation, parole, or mandatory supervised release. (Section 2-110(a-5) of the Act) Reasonable access under this provision shall not interfere with the identified offender's medical or psychiatric care.

2) The facility staff shall meet with local law enforcement officials to discuss the need for and to develop, if needed, policies and procedures to address the presence of facility residents who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense, including compliance with Section 300.695 of this Part.

3) Every licensed facility shall provide to every prospective and current resident and resident's guardian and to every facility employee, a written notice, prescribed by the Department, advising the resident, guardian, or employee of his or her right to ask whether any residents of the facility are identified offenders. The facility shall confirm whether identified offenders are residing in the facility.

A) The notice shall also be prominently posted within every licensed facility.

B) The notice shall include a statement that information regarding registered sex offenders may be obtained from the Illinois State Police

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website, www.isp.state.il.us <http://www.isp.state.il.us>, and that information regarding persons serving terms of parole or mandatory supervised release may be obtained from the Illinois Department of Corrections website, www.idoc.state.il.us <http://www.idoc.state.il.us> (Section 2-216 of the Act)

4) If the identified offender is on probation, parole, or mandatory supervised release, the facility shall contact the resident ' s probation or parole officer, acknowledge the terms of release, update contact information with the probation or parole office, and maintain updated contact information in the resident ' s record.

g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part.

h) Facilities shall annually complete all of the steps required in subsection (f) of this Section for identified offenders. This requirement does not apply to residents who have not been discharged from the facility during the previous 12 months.

i) For currents residents who are identified offenders, the facility shall review the security measures listed in the Identified Offender Report and Recommendation provided by the Department of the State Police.

j) Upon admission of an identified offender to the facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident ' s needs in an individualized plan of care.

k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offenders care plan. (Section 2-210.6(f) of the Act)

l) If the identified offender is a convicted (see 730 ILCS 150/2) or registered (see 730 ILCS

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150/3) sex offender or if the Identified Offender Report and Recommendation prepared pursuant to Section 2-210.6(a) of the Act reveals that the identified offender poses a significant risk of harm to others within the facility, the offender shall be required to have his or her own room within the facility subject to the rights of married residents under Section 2-108(e) of the Act. (Section 2-210.6(d) of the Act)

m) The facility's reliance on the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the Act shall not relieve or indemnify in any manner the facility's liability or responsibility with regard to the identified offender or other facility residents.

n) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and shall document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents.

o) Incident reports shall be submitted to the Division of Long Term Care Field Operations in the Department's Office of Health Care Regulation in compliance with Section 300.690 of this Part. The facility shall review its placement determination of identified offenders based on incident reports involving the identified offender. In incident reports involving identified offenders, the facility shall identify whether the incident involves substance abuse, aggressive behavior, or inappropriate sexual behavior, as well as any other behavior or activity that would be reasonably likely to cause harm to the identified offender or others. If the facility cannot protect the other residents from misconduct by the identified

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offender, then the facility shall transfer or discharge the identified offender in accordance with Section 300.3300 of this Part.
p) The facility shall notify the appropriate local law enforcement agency, the Illinois Prisoner Review Board, or the Department of Corrections of the incident and whether it involved substance abuse, aggressive behavior, or inappropriate sexual behavior that would necessitate relocation of that resident.
q) The facility shall develop procedures for implementing changes in resident care and facility policies when the resident no longer meets the definition of identified offender.
(Source: Amended at 35 Ill. Reg. 11419, effective June 29, 2011)

Based on record review and interview, the facility failed to follow up with the Illinois State Police to secure an identified offender risk status assessment for one resident with a history of a felony conviction(R61) and to care plan for one resident's (R6) identified offender status of nine residents whose background check data were reviewed. This has the potential to affect all 106 residents living at the facility.
Findings include:
R61's background check information from 03/10/16 showed R61 has a history of a felony conviction for arson. On 07/05/16 at 10:40 am, E16, Business Office Manager, stated R61 was fingerprinted on 03/14/16. E16 stated after the resident is fingerprinted, the facility receives notification within a few days from the Illinois State Police that an appointment has been scheduled to interview the resident to assess their offender risk level as low, moderate, or high. As of the date of interview, 07/05/16, the facility has not been contacted by the Illinois State Police with any follow up information about the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001317	A. BUILDING: _____ B. WING _____	C 07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAHOKIA NURSING & REHAB CENTER	2 ANNABLE COURT CAHOKIA, IL 62206

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25	S9999		

offender risk status and E16 stated the facility has not called the agency to check. E16 stated she normally audits these monthly and should have caught this issue in April 2016 and followed up on it, but did not do so, and stated, "I'll call right now."
Review of R6's background check information from 04/24/10 showed R6 has a history of a felony conviction for theft. R6's Care Plan with a review date of 03/15/16 showed no problem area nor interventions related to R6's offender status.
On 07/05/16 at 2:30pm E30, Care Plan Coordinator, stated she did not care plan R6 for this because was she unclear as to why R6 was identified as an offender because the family was giving conflicting information, and stated,"The resident is essentially comatose-he isn't going to do anything."
A Resident Census and Conditions form dated 06/02/16 showed a census of 106 residents residing at the facility.
(B)

IMPOSED PLAN OF CORRECTION
NAME OF FACILITY: Cahokia Nursing & Rehab Center
DATE AND TYPE OF SURVEY: July 12, 2016 Complaint# 1642969/IL85889

Licensure Violations

300.610a)
300.670a)c)1)2)3)d)
300.1210b)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.670 Disaster Preparedness

a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility.

c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to:

1) Ensure that all personnel on all shifts are trained to perform assigned tasks;

2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and

3) Evaluate the effectiveness of disaster plans and procedures.

d) Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident*

This will be accomplished by:

I. The facility will conduct an investigation of the incident and take appropriate actions. The assessments for all residents identified as high risk for 'accidental injury' or adverse effects as a result of incorrectly implementing facility's fire evacuation will be reviewed and the facility's Fire Safety and Disaster Preparedness policy will be revised as necessary based on the outcome of the review.

II. All staff will be in-serviced on Fire Safety and Disaster Preparedness Policy and Procedures. The in-services will include all staff and will cover, at a minimum, roles of staff, effective communication during an emergency and importance of implementing correct procedures to minimize any avoidable outcomes. The facility will provide fire and disaster drills including simulation per state requirements. The facility will evaluate and make necessary changes to facility's policy and procedures as it relates to facility's patient care needs.

III. Documentation of in-service training, assessments and related follow-up actions will be maintained by the facility.

IV. The Administrator and Director of Nurses will monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

Completion Date: Ten days from receipt of the Imposed Plan of Corrections.

Attachment B
Imposed Plan of Correction

JB/Cahokia Nursing & Rehab Center/08/23/2016